



UNIVERSAL HEALTH SERIES

INSTITUTIONALIZATION OF THE SYSTEM OF HEALTH ACCOUNTS SHA 2011 IN LATIN AMERICA

PAHO



Pan American
Health
Organization



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REGIONAL OFFICE FOR THE
AMERICAS

INSTITUTIONALIZATION OF THE SYSTEM OF HEALTH ACCOUNTS SHA 2011 IN LATIN AMERICA

Washington, D.C., 2022

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PAHO/HSS/HS/21-0014

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ABBREVIATIONS AND ACRONYMS

GDP	gross domestic product
GHED	Global Health Expenditure Database
HAPT	Health Accounts Production Tool
PAHO	Pan American Health Organization
SHA 2011	System of Health Accounts 2011
WHO	World Health Organization



INTRODUCTION

With the publication of *A System of Health Accounts 2011* (SHA 2011) as the standard methodology for measuring health spending around the world, it was expected that its use would be consolidated worldwide (1). Some countries in the Region of the Americas adopted the initial framework starting in 2000, and then migrated to the updated version (SHA 2011), which has been the international benchmark since 2016 (2). Standard reporting of health expenditure figures has been facilitated by the Global Health Expenditure Database (GHED) of the World Health Organization (WHO). For annual updates, countries with health accounts teams report their spending or submit the respective studies to generate basic indicators; in other cases, estimates are made by WHO technicians and validated by the countries. The objective of this document is to establish whether the standard SHA 2011 has led to the institutionalized measurement of health expenditure in Latin America and the Caribbean.

This publication provides information from a survey conducted at the regional health accounts meeting held in Panama in September 2019 (3), to which 14 of the attending delegations responded.¹ The objective is to identify elements that can be used to review the strategy for institutionalization of health accounts in the countries of the Region. As background, there is a review of the establishment and expansion of the accounts in Latin America, as well as the approach to institutionalization, according to health accountants around the world. The survey results describe the perspective of accountants in the Region. This publication concludes with final reflections on next steps and recommendations for advancing the institutionalization of SHA 2011. The efforts made should result in improved quality and benefits for health systems: more relevant accounts, produced regularly, efficiently and effectively.

1 Argentina, Bolivia (Plurinational State of), Brazil, Chile, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, and Uruguay. Some delegates did not respond and others who responded to the survey were relatively new and therefore unfamiliar with some of the background information.

CHAPTER 1



WHAT IS THE INSTITUTIONALIZATION OF HEALTH ACCOUNTS?

According to WHO (4), institutionalization involves preparing and using the results of health accounts. The three strategic components that WHO points to for institutionalizing accounts are: data collection; production of accounts; and use of results in decision-making at the various levels of governance and operation of the health system.

Institutionalization builds on the local capacity to produce accounts in a regular, cost-effective, and timely manner for decision-making, allowing for a greater contribution to policymaking as a complement to other instruments (e.g., financing matrices, costing tools, etc.). It also means facilitating ownership of the results and their integration into decision-making at various levels of the health system. The accounts are an essential tool for the system's governance, since they show expenditure flows by component, thus ensuring their coordination and complementarity with other policy instruments (e.g., subsidies and regulations).² Even if those responsible for governance do not work directly with the results of SHA 2011, the generated indicators favor governance and equity, effectiveness, and efficiency in the allocation of resources needed to achieve universal health goals (5).

The paradox is that, in practice, despite recognizing their value in informing policy decisions, few countries in the Region produce and use the estimates generated under the framework of SHA 2011 in a systematic and institutionalized way – and when they do, such use is not documented.

For the results of the health accounts to be used, they must contribute health expenditure data that can support, monitor, and evaluate the processes of transforming systems toward universal health. Preferably, they should be generated under the same framework, so that expenditure monitoring can benefit from both national and international comparisons and over time. Continuity in the production of health accounts will, in the short term, allow data to increasingly meet statistical quality criteria: relevance, accuracy, reliability, completeness, coherence, comparability and compatibility with other associated statistical systems (6).

To serve as a basis for monitoring and evaluation, the accounts require a stable institutional setting, methodologically independent of policy. This entails a structured organization of knowledge to facilitate operational continuity, which is important when considering personnel turnover. People come and go, but organizations and their functions remain relatively stable.

2 Governance in the health system refers to the rules, institutions, and policies that guide its functioning, regulate the participation of the various actors, and use the available resources to ensure quality health care for the entire population. Source: Sabignoso M. Los cinco atributos clave de la buena gobernanza en los sistemas de salud. Gente Saludable (blog). [The five key attributes of good governance in health systems. Healthy People (blog)]. Inter-American Development Bank; 29 August, 2018. Available from: <https://blogs.iadb.org/salud/es/5-atributos-de-la-buena-gobernanza-en-salud/#:~:text=El%20consenso%20sobre%20su%20defnici%C3%B3n,cuidados%20de%20salud%20de%20calidad.>

CHAPTER 2



WHAT DOES INSTITUTIONALIZATION DEPEND ON, ACCORDING TO THE WORLD'S HEALTH ACCOUNTANTS?

In 2016, during the SHA 2011 global Meeting of Health Accounts Experts in Geneva, feedback was gathered from participants, who proposed the conditions that, based on their experience, would facilitate institutionalization (7).

Their recommendations include:

- **Planning:** A crucial first step in ensuring that the production of health accounts runs smoothly is to create an action plan and ensure that all the necessary resources are in place before the country starts producing them.
- **Production:** All the countries wish to institutionalize health accounts to ensure the regular and timely collection and production of data. To do so, they recommended that the production of health accounts be cost-effective.
- **Utilization:** Health accounts data should be used to inform health financing and spending policy. SHA 2011 provides an internationally standardized framework that is flexible enough to adapt to the information needs of each country's policies.

Under SHA 2011, health accounts data (either independently or with other information) can be used to:

- characterize health systems and monitor performance;
- inform policymakers and other stakeholders about financial sustainability and determinants of expenditure;
- assess whether resources can be used more efficiently or reallocated to better align with long-term priorities;
- formulate key reforms and initiatives and monitor their progress toward universal health objectives and the Sustainable Development Goals;
- help countries compare their indicators over time and internationally.

It was noted that the major persistent challenges include “:” the complexity of the SHA 2011 methodology, dependence on foreign technical assistance, costly and time-consuming estimation when there is a lack of continuity, and “the difficulty in facilitating production without adequate metadata on basic elements such as records of decision-making and accounting assumptions.”

It has been suggested that the ideal situation lies both in having adequate information systems in place, and in ensuring that government agencies use health accounts data to inform their decisions (8).

CHAPTER 3



ADVANCES IN THE INSTITUTIONALIZATION OF SHA 2011 HEALTH ACCOUNTS IN THE REGION

To date, there has been no systematic reckoning of the problems faced specifically by health accountants in the countries of the Region of the Americas. This report seeks to bridge this gap.

Regarding the needs and potential of institutionalized accounts, three points should be considered:

1. The Pan American Health Organization (PAHO) supports the institutionalization of accounts in Latin America and the Caribbean. To ensure progress toward universal health, PAHO Member States asked the Secretariat to prioritize technical cooperation activities that would help them measure their progress. In this context, health accounts are an important element for the necessary monitoring of public policies. Several strategies have been developed to facilitate the understanding of the SHA 2011 framework, including ongoing support through technical cooperation, at the request of country teams; technical training workshops and methodological discussion at the national level; regional and subregional workshops to discuss and improve methodologies; regional workshops to validate expenditure data using the SHA 2011 methodology;³ and the first online health accounts course, through the Public Health Virtual Campus, piloted in 2018 (9). The relevant materials have been translated so that there are bilingual versions in English and Spanish. It is expected that a second edition of the course will be offered, in which the practice and exercises will be expanded to cover basic use of the production software (HAPT), including the new 2021 version of the tool. These activities are expected to help professionalize the generation of health accounts.
2. Many countries are now implementing or have implemented some form of health accounts (SHA 2011 or another framework); however, because they have not been institutionalized, the benefits have been only partial, and their quality has been lower than would be possible with the information available in the country. There is also still work to be done to improve the quality and use of the information systems that feed the accounts. A first step is to generate complete accounts. To do this, the minimum SHA 2011 classifications include revenue, schemes, provision, and functions with current expenditure, plus gross capital formation. They are also expected to cover all existing stakeholders in the country. And given the relevance of the Sustainable Development Goals, it is also essential to have a proper estimate of primary care spending as well as the allocation of spending by disease.
3. In the Region, efforts have yet to be made to capitalize on and integrate dispersed knowledge in health accounts. The Region can not only benefit from technical discussions to reflect on and assimilate its history with health accounts but can also share the essential elements of its experience with other regions.

³ The courses were attended by representatives of the following countries and territories: Argentina, Aruba, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Costa Rica, Curaçao, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Panama, Paraguay, Peru, Sint Maarten, Suriname, and Uruguay. Other countries, such as Cuba and Venezuela (Bolivarian Republic of), have also participated in regional SHA 2011 discussion meetings.

CHAPTER 4



RESULTS OF THE SURVEY ON INSTITUTIONALIZATION WITH HEALTH ACCOUNTS MANAGERS IN LATIN AMERICA

4.1 Essential components of institutionalization

Health accountants from the Region discussed the three strategic components identified by WHO and described above: data collection; production of accounts; and use of results in decision-making at the various levels of governance and operation of the health system. The following is a brief description of their responses.

4.2 Institutionalization of data collection

4.2.1 Information system support

Information systems in Latin American countries are not fully integrated, and data are only partially processed and used. Often, there are parallel reporting systems that overlap in content, without being complementary. In some instances, work is still done manually and on paper, which requires more time and effort (8). Expenditure estimates require extensive information, with a level of detail difficult to obtain in the countries of the Region; this challenge has been met gradually by supplementing the information from different sources.

The accounts are usually based on statistics from the system's institutions, such as the Ministry of Health and Social Security, Ministry of Finance, Ministry of Defense, Central Bank, National Statistics Office, and National Health Authority. The sources of information are combined, including national accounting (system of national accounts). This information is then adjusted to the specific needs of SHA 2011, and this process determines the coverage of the results by type of classification (Table 1).

Table 1. Availability of information reported by surveyed countries, 2019

Type of content	Existence in the 14 countries surveyed
Total amount of healthcare expenditure and origin of funds	Exists in 12 countries 2 countries did not respond
Expenditure by healthcare providers	Exists in 12 countries 2 countries did not respond
Expenditure by input	Exists in 12 countries with public sector data Exists in 2 countries with private sector data 2 countries did not respond
Health services (functions)	Exists in 11 countries Does not exist in 1 country 2 countries did not respond
Expenditure by disease	Exists in 11 countries Does not exist in 1 country 2 countries did not respond
Capital expenditure	Exists in 8 countries with public sector data Exists in 3 countries with private sector data Does not exist in 1 country 2 countries did not respond

Only Mexico has a specific information system with national coverage, based on the existing expenditure and budget information system, which was adapted by the Ministry of Finance to the needs of SHA 2011 (10). In other countries, the budget structure is not adapted to the health accounts but must be adjusted to cover the basic itemization of the accounts.

The budget and financial system in countries include data on expenditure and sources used and who provides these. This means that in most cases it is feasible to establish the amount of health spending and the distribution of the financial burden by source of funding (SHA 2011 revenue classification). The existing data is considered sufficient to provide information on the health coverage by population and income groups (reflected in the SHA 2011 financing schemes and other classifications such as by beneficiary characteristics). It is also feasible to identify the agencies responsible for allocating and purchasing of the goods and services (financing agents).

The measured expenditure amounts also cover, in most cases, the purchase of services according to the units providing these services (service providers) as well as, at least partly, to the services provided (SHA 2011 functions of health care). Since budgets include data on the type of input used to produce health services (factors of provision), it is feasible, in most countries, to document spending on human resources and medicines. This information is usually limited to public agencies as information from the private sector is only available on an exceptional basis .

Financial information includes expenditure on certain services (expenditure by function). However, documenting the totality of services in detail (e.g., by type of preventive care) may require additional effort that is not always undertaken. Health accounts have statistical strategies to allocate expenditure aggregates in greater detail according to function, based on non-financial information.

There is widespread interest in obtaining expenditure allocations by disease. In most countries where this information is not available, allocation keys are used.

Investment in capital goods is critical to expanding quality care coverage. The available capital expenditure information, however, is mainly from the public sector.

As in other statistical exercises, the quality of the results depends on the information used to calculate them; this is known as “garbage in, garbage out”. The information system can be improved. A minimum proposal from the health accounts would be to establish the necessary data and promote the progressive alignment of the reporting system.

4.2.2 Automating data collection

Access to information is a precondition for estimation. The idea is to identify the necessary and existing information. Awareness should be raised, and agreements made with data providers to ensure that they supply data in a systematic and automated manner. Official contact between the agencies that generate the accounts and those that produce the information would ensure the provision of the information in the required time and format. The time and effort that the group of accountants would save would allow them to concentrate on more complex components that increase the added value of the accounts.

Some countries reported having obtained a small amount of funding to outsource the programming of the budget execution data output exactly as it can be loaded into the Health Accounts Production Tool (HAPT) (11). This is a minimal investment to facilitate and speed up the work and reduce the risk of errors.

4.2.3 Enhancing the responsibility to produce information

It was noted that one of the enabling factors is the presence of an interagency health accounts committee. The participating institutions are important and depend on the composition of the country's health system, including representatives of public and private entities. The committees generally consist of about 10 members, and public institutions are mainly represented by the Ministry of Health and Social Security. When there are parallel health systems, such as the Ministry of Defense, they are invited to participate. Private entities are usually represented by public regulatory bodies, such as insurance supervisory agencies, statistics offices, and the Central Bank, associated with national accounting and its registers.

The responsibility for generating information involves the active participation of the health system and its users. The biggest challenge has been obtaining information from the private sector.

For instance, in Costa Rica, a change was made to the Statistics System Law, which now establishes financial penalties for those who fail to provide the requested information (12). In other words, the provision of information is mandatory, and noncompliance carries a financial penalty.

Besides data generation, the steps taken to produce the accounts and ensure proper interpretation and use of the results should be documented. Metadata contributes to quality and institutionalization.

4.3 Institutionalization of the production of accounts

4.3.1 Formally assigning a place or institution in charge

It is expected that the accounts will be generated annually and that this will professionalize the activity, allowing the participants to accumulate experience in all of its aspects. It is easier to achieve continuity of estimates under a single standard when an institution is designated for this purpose, with an identifiable and permanent location. The sporadic use of consultants is not appropriate if it is impossible to accumulate experience and build capacity in the department in charge (Table 2).

Broadly speaking, it can be said that at the institutional level nearly all responding countries have health accounts. There is usually a specific unit responsible for preparing health accounts, linked to planning departments. Health economics units, when they are active, are also involved, but this is not the most common scenario. Sometimes, interagency support is received through a national health accounts group or committee. At the moment, there are regulatory processes to strengthen this assistance, since in most cases it is not operational. In the four countries where it is operational, decrees have been enacted to support it.

There is often a stable and skilled group of accountants to produce the health accounts. However, this is not usually their sole function. In addition, they often work without a specific budget. This is a critical point for further studies. Arguably, the budget shortfall would be covered with support from the university sector, research, and the national information system to provide the necessary data, but coverage, quality, and access are not currently guaranteed. Cooperation and coordination are not institutionalized.

Table 2. Production of health accounts, survey of Latin American countries, 2019

Production of health accounts	Situation in the 14 countries surveyed
Health accounts unit	12 countries have a specific health accounts unit
Specific group of accountants	10 countries have a stable team
Quality controls	5 countries use trend analysis
	4 countries analyze coverage achieved
	4 countries use national accounting data as a reference for quality control
	5 countries do not include complete metadata in reports
	10 countries regularly interact with the national statistics institute

4.3.2 Ensuring standards

Generating data with the necessary quality and content is another precondition for institutionalization. Facilitating access to adequate and complete information, as well as standardizing reports with useful data to generate accounts, is an advance in the information systems as a whole. The data entered must correspond to the expected content, according to the needs of the framework, and considering the respective classification and categories. The idea is to reflect the country's health spending position. In this sense, it is important to ensure the integration of private spending. To assess the effectiveness and equity of public spending, data must be collected from the private sector, including from households.

The quality of the data generated must also be ensured. It is not common for countries to perform quality control through trend analysis of the data obtained; nor is it common to analyze the coverage achieved in the estimates or to use national accounting data as a reference for quality control. It is also necessary to ensure the inclusion of complete metadata in the reports. Experiences should be shared with specialized agencies, such as national statistics institutes, regarding quality control and data presentation.

4.3.3 Institutionalization of data use

The effort to generate accounts is associated with the need to make informed decisions to achieve effective and efficient results with the greatest impact. The potential uses are diverse, and it appears that countries can expand the benefits they derive from the accounts. This would be, to a large extent, a shared experience if all production, conditions, and results obtained were systematically documented. Countries have been encouraged to generate evidence and expand the publication of results in different formats that are attractive and reach potential users, such as policy briefs, case studies, and press releases.

4.3.4 Generating interest in the results

The ability to communicate the results and contents of the accounts is a prerequisite. Consideration should be given to serving different audiences, each of which may have specific interests. Priority should be given to selective communication, but in a manner consistent with the contents: decision makers, universities and research centers, civil society organizations, media, patients, general public, etc.

Costa Rica, for example, considered the possibility of facilitating this process by collaborating with communications professionals for the presentation and dissemination of results.

The information is often available to be used freely (Table 3). It is important to ensure that data are disclosed, whether through policy briefs or press releases. Sometimes data are disseminated only internally, although in some countries they are published on the institution's websites. Strictly speaking, the countries do not engage in disclosure, since communication is rather technical. In fact, data are only partially disclosed to the subnational levels. This communication takes place only in about 50% of the countries that responded to the survey. Communication with users of the information is even less frequent, as is the discussion of results with the scientific community.

Table 3. Dissemination and use of information

Dissemination of results	Practice among surveyed countries
Dissemination (e.g., policy briefs)	6 countries report their data
Special preparation for users	4 countries interact with data users
Discussion with the scientific community	2 countries discuss with the scientific community

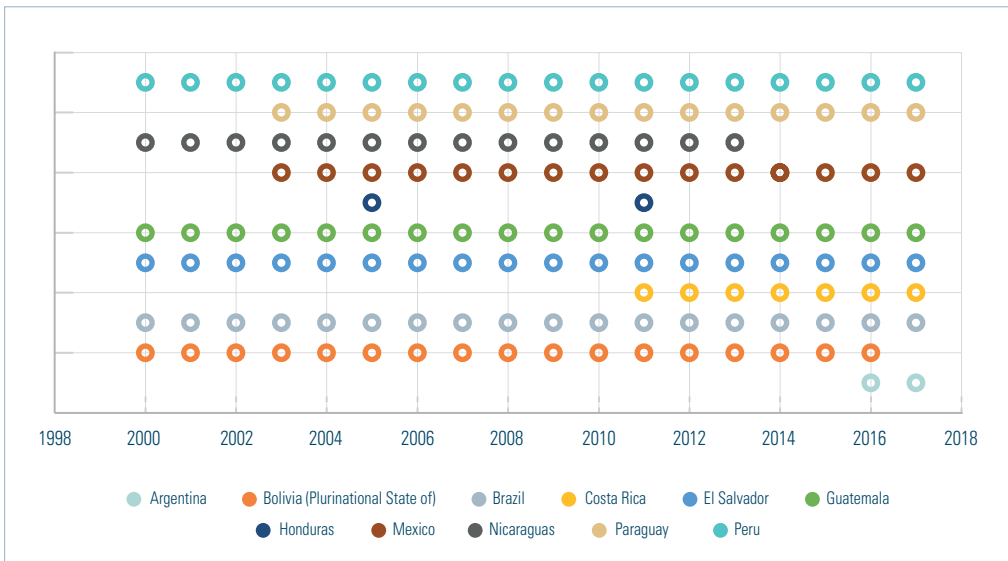
4.3.5 Creating demand by linking timely results and policy decision-making

Facilitating the interpretation and application of the results through targeted thematic communications can increase demand for the results of the accounts. Therefore, the suggestion is to explore the possibility of producing policy briefs based on the reports and adapted to the context of each country.

The health accounts data published in GHED cover the period from 2000 to the present, with a two-year lag. There are 144 cumulative years of reported health accounts in Latin American countries for the period between 2000 and 2019 (Figure 1). However, only four countries report using the results of health accounts to evaluate and design health-related policies; in only six cases are the results discussed and analyzed in the scientific community.

The most commonly used SHA data are total health spending, out-of-pocket spending, spending in relation to gross domestic product (GDP), and total public spending. Household expenditure is also important as well as the per capita values of the indicators. Additional information contained in the accounts, such as health employment, is also considered useful. The importance of the sector in the economy can be represented as a share of GDP but also as a share of consumption and added value.

Figure 1. Health accounts in 2000–2017 of countries in the Region that responded to the survey, 2019



Source: Based on data reported by countries.

4.4 Progress and needs in institutionalization

4.4.1 Key aspects of supporting institutionalization

Factors deemed necessary to generate and use the accounts include political will, technical knowledge of the authorities, and empathy and collaboration among the members of the technical committee, i.e., between organizations within the health system. In several countries, this is achieved through more formal initiatives, for example, through a presidential decree formalizing collaboration, transparency, and open data policies. Brazil favors the distribution of activities among several organizations, which not only optimize capacities, but also collaborate at different levels of the system.

Having a specific budget line also ensures the continuity of the human resources involved in the production of the accounts. When remunerations and operating expenses are covered, it is possible to carry out special studies that make the estimates more reliable, thus facilitating the evaluation of health expenditure.

The role of international organizations – and particularly PAHO – in training and motivation has been crucial for continuity. The opportunity for an annual discussion of the expenditure indicators and data to be presented to GHED and the periodic technical discussion, plus the additional resources, has helped sustain interest. These activities are largely based on PAHO/WHO technical cooperation.

Having a comprehensive information system will allow for the complementary use of all the variables needed to prepare the accounts and indicators useful for political decision-making. There is a need not only for financial data but also data on the activities in which resources are consumed; in addition, the data must be disaggregated to the level needed to produce the expected indicators. It is also ideal to have the appropriate means and tools to make projections and generate current and even future information on public policy measures (e.g., simulations). Strengthening health systems means having timely information.

4.4.2 The main barriers to institutionalization

The main barriers include discontinuation of the mandate to generate health accounts. This reflects the absence of prioritization of “intelligence” information on health spending. The Ministry of Health’s steering role and governance is hindered when the different stakeholders fail to provide information. For this reason, it is considered important that there be an interinstitutional health accounts commission to facilitate the exchange of information and knowledge in a broad and decentralized manner.

Another factor deemed indispensable is, once again, the availability of an appropriate information system, strengthened with information technologies. Coordination between these systems will, among other things, reduce individual budget coding by province/state or entity and facilitate the standardization of data by the various stakeholders. Interinstitutional communication leads to the establishment and continuity of commitments such as the exchange of quality information.

Lack of access to existing information – especially from the private sector and often due to the lack of an up-to-date income and expenditure survey – has a negative impact on estimates of out-of-pocket spending. Applying innovative strategies and methodologies, such as small sample studies, would help to address the stages of data insufficiency. This and other strategies would be feasible with the cooperation of statistics offices and academia. Currently, however, the lack of formal communication mechanisms with these institutions poses a challenge even in terms of understanding the SHA 2011 methodological framework and its role in describing the health system from an expenditure standpoint.

Given the limited resources, it is necessary to establish optimization strategies, which are achieved through interinstitutional cooperation and coordination. The results of the survey of health accountants show that shortfalls in budget, methodological training, and staffing – both in terms of number and tenure – are critical elements. Frequent turnover reflects the difficulty of keeping staff in the department.

Furthermore, the results are either not well disseminated, not known, or only used occasionally, rather than used as a tool for the ongoing oversight or monitoring of resources. This problem is linked precisely to the lack of institutionalization, since the production of health accounts is often an infrequent event, driven by external donors, revealing a lack of ownership. Local factors, such as the absence of appropriate metadata reporting (e.g., contacts, sources of information, and estimation methods used), must also be considered. Another factor is the lack of proper communication between producers and users.

4.4.3 Resources needed to move forward

Accountants in the Region agree that political support from the highest levels is important for information and data governance, specifically: political support to strengthen the progress made, even when there are changes in government; and data governance support to involve subnational sectors (provinces, etc.) and consolidate interinstitutional cooperation and collaboration.

Political support is the basis for strengthening the information system and integrating data to generate account information. It can be provided through laws that require institutions to provide timely information for the preparation of health accounts.

The survey reveals that staff turnover and lack of full-time commitment are a major obstacle to institutionalization. Given the frequency of staff turnover, which can be intermittent, this problem should be monitored to develop strategies that favor and facilitate the continuity of account production. To remedy the lack of full-time staff commitment, the preparation of accounts should be facilitated and automated as much as possible. Annual reporting by the data-producing institutions should also be institutionalized.

As for organization, it is crucial to centralize the work in a department where economic and health knowledge is available for the efficient production and analysis of accounts. The formal establishment of a health economics department and an interinstitutional committee strengthens cooperation on data. It is also the basis for strengthening analytical capacity in the country and integrating the results of the accounts into an evidence-based process for decision-making in the health system, in support of national and institutional managers, etc. This can be encouraged by specific activities involving interaction with institutional groups to secure their collaboration and increase ownership of the results. It is not enough to hold final workshops to present the results; strategies for broad dissemination of the health accounts are also required to support decision-making at various levels.

All this must be supported by establishing a specific location in the health authority's organizational chart and a specific budget for the preparation of accounts and complementary activities. It is imperative that the accounts be cost-effective, but this will be possible only if a capable group is institutionalized to provide continuity, with quality and openness, in the specialized management of information on health financing and spending. Professional standardization of the figures, as part of the system's regular operation, will make it possible to compare results and progress over time and between countries.

CHAPTER 5



FINAL REFLECTIONS

There are three key areas for the proper development of accounts, constituting the central aspects of institutionalization: governance, technical and institutional capacity, and the availability of necessary financing. These factors are reflected in the survey results.

The survey also reflects that the critical points identified by WHO in 2011 are relevant to the development of accounts in the Region. Accounts require information and must be supported by a clear mandate and formal collaborations with all potential information providers. By clearly establishing what data are needed in the accounts, it should be possible to encourage a progressive alignment of information systems, and these needs should be included alongside existing monitoring. For example, household expenditure surveys will need to be conducted in accordance with the associated updated international classification – that is, with the Classification of Individual Consumption According to Purpose (COICOP) in its 2018 version (13), which has been aligned with the SHA 2011 classification.

In terms of impact, accounts are used in policy evaluation and updating, but the results of this survey do not seem to show this. A specific study is needed to document the uses in detail, and the associated results in the Region. Some of the uses by academia and the scientific community have been very relevant. Recognizing the usefulness of the accounts helps to make them an institutional priority, keeping them from being dependent on individual or circumstantial decisions.

The accounts must generate the necessary indicators for the governance of the health system. Spending and resource flows are a very policy-sensitive component and should be available (for technical use and evidence production) to those responsible for operationalizing governance. Dissemination of the results should be complemented by the link between those responsible for producing the accounts and those responsible for operational governance, encouraging transparency and accountability in the monitoring of resources.

Finally, the survey results reveal challenges for PAHO/WHO technical cooperation:

1. Although the WHO questionnaire to update the GHED annually has facilitated institutionalization, it needs to be discussed further so that countries understand its content and can better integrate it.
2. The lag in published figures, which are usually based on data from two years earlier (t-2), is perceived by decisionmakers as a loss of opportunity. This is accentuated in countries where several years' accounts are done simultaneously. PAHO has proposed strategies to generate more timely results. A methodology for making projections is now being developed, which should be a positive contribution.

There may be a vicious circle that could lead to the accounts becoming irrelevant, associated with their insufficient linkage to decision-making and lack of timeliness, continuity, quality, and relevance.

To turn this situation into a virtuous circle, a structured and active monitoring of institutionalization is needed to ensure compliance with certain conditions:

- a) the results of the accounts are of good quality and specific monitoring of their development is established;
- b) mechanisms are put in place to generate results in the short term, in an agile (cost-effective) and timely manner;
- c) the system is used to make current decisions, linking the results to discussions on the transformation toward universal health.

Another essential effort, in parallel, is to ensure that those in charge of the information systems of the different data-providing institutions receive clear indications regarding what information is needed. Systems should be established to record information needs for policy purposes, so that reports include indicators and texts that facilitate their use.

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The measurement of health spending and the monitoring of resources through the System of Health Accounts 2011 represent invaluable tools for decision-making and the adoption of health policies. Knowing how much is being spent and how it is being spent allows, for example, to verify whether spending is linked to a country's policy priorities; whether the resources of the system are translated into greater and better health benefits; and whether the resources are allocated according to the specific health needs, and therefore achieve the maximum potential of benefits for the population. This strategic information facilitates the monitoring of progress towards the objectives of access and universal coverage of the system from financing, with efficiency, equity, and sustainability.

This publication describes the data from a survey of health accountants in countries in the Region of the Americas with the objective of analyzing the key elements to improve the institutionalization strategies of health accounts in the countries. It reveals that the frequency of staff turnover and insufficient resources represent obstacles to full institutionalization. The background to the establishment and expansion of the accounts in Latin America and the disclosure practices of the most frequent results are also described. The publication concludes with final thoughts and recommendations.

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Pan American
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REGIONAL OFFICE FOR THE
Americas

525 Twenty-third Street, NW
Washington, D.C., 20037
United States of America
Tel.: +1 (202) 974-3000
www.paho.org